Ordered Liberty Mental Health Crisis Care Act

Model State Legislation

Section 1. Short Title

This Act shall be known and may be cited as the “Ordered Liberty Mental Health Crisis Care Act.”

Section 2. Legislative Findings and Purpose

(a) Findings

The Legislature finds that:

1. Individuals experiencing severe mental illness are entitled to inherent dignity, due process, and restoration of agency.
2. The absence of structured crisis care has resulted in:
    - increased homelessness,
    - repeated emergency department utilization,
    - incarceration of mentally ill individuals without treatment,
    - destabilization of families and communities.
3. Prior institutional systems failed due to:
    - violations of civil liberties,
    - lack of due process,

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    - centralized and unaccountable authority structures.

4. A just system must:
    - preserve liberty while addressing incapacity,
    - operate under subsidiarity, with authority closest to the affected community,
    - ensure oversight flows upward through representation, not downward through command.

(b) Purpose

The purpose of this Act is to establish a rights-preserving, community-rooted continuum of mental health crisis care that:

1. stabilizes individuals in crisis,
2. restores personal agency,
3. reduces systemic burden on emergency and correctional systems,
4. prevents abuse through enforceable safeguards.

Section 3. Definitions

For purposes of this Act:

- “Crisis Stabilization Unit (CSU)” means a short-term clinical facility providing stabilization for up to 5 days.
- “Acute Psychiatric Care Facility” means a licensed inpatient setting for short-term psychiatric treatment.

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- “Subacute Recovery Facility” means a structured, non-carceral residential setting for extended recovery.
- “Grave Disability” means a condition in which an individual, due to mental illness, is unable to provide for basic personal needs essential to health and safety.
- “Least Restrictive Alternative” means the lowest level of intervention sufficient to ensure safety and stabilization.
- “Assisted Outpatient Treatment (AOT)” means court-ordered outpatient care subject to due process protections.
- “County Crisis Care Board” means the local governing body established under this Act.

Section 4. Establishment of the Continuum of Care

(a) Required System Components

Each county or designated regional authority shall ensure access to:

1. Mobile Crisis Response Services (24/7)
2. Walk-In Crisis Centers (No Wrong Door Access)
3. Crisis Stabilization Units (CSUs)
4. Acute Psychiatric Care Facilities
5. Subacute Recovery Facilities
6. Supportive Housing with Integrated Services

(b) Integration Requirement

All components shall operate as an integrated system, ensuring continuity of care and eliminating discharge gaps.

Section 5. Rights and Liberties Protections

(a) Foundational Standard

No individual shall be deprived of liberty except under clearly defined criteria, due process, and time-limited authority.

(b) Emergency Detention

1. May be initiated only upon:
    - licensed clinical determination of imminent danger or grave disability.
2. Duration shall not exceed 72 hours without judicial review.

(c) Judicial Commitment Process

1. A hearing shall be required for any continued involuntary care.
2. The individual shall have:
    - right to legal counsel,
    - right to independent evaluation,
    - right to present evidence and witnesses.
3. Standard of proof: clear and convincing evidence.
4. Orders shall be time-limited and subject to mandatory review.

(d) Least Restrictive Requirement

Courts and clinicians must affirmatively demonstrate that:

- no less restrictive alternative is sufficient to ensure safety and stabilization.

(e) Prohibited Uses

Under no circumstances shall this system be used for:

- detention based solely on poverty or homelessness,
- suppression of lawful beliefs or expression,
- eugenic practices or population control,
- indefinite or undefined confinement.

(f) Restrictive Interventions

1. Seclusion and restraint:
    - may be used only as a last resort,
    - must be time-limited and documented,
    - shall trigger automatic review.
2. Forced medication:
    - permitted only under emergency conditions or court authorization.

Section 6. Patient Advocacy and Civil Liberties Oversight

(a) Independent Patient Advocate

Each individual under involuntary care shall be assigned an independent advocate not employed by the treating facility.

(b) Civil Liberties Ombuds Office

The State shall establish an independent office with authority to:

- investigate complaints,
- conduct inspections,
- enforce compliance with this Act.

(c) Mandatory Review Triggers

Automatic review shall occur upon:

- death,
- serious bodily harm,
- repeated use of restraint,
- credible allegations of abuse.

Section 7. Subsidiarity Governance Structure

(a) County Crisis Care Boards

Each county or regional authority shall establish a board responsible for:

- system planning,
- facility oversight,
- contracting and coordination,
- community integration.

(b) Composition

Boards shall include:

- clinical professionals,
- emergency services representatives,
- civil liberties representatives,
- peer and family advocates,
- local government representatives.

(c) Authority Structure

1. Primary authority resides at the county or regional level.
2. The State shall:
    - set minimum standards,
    - ensure rights protections,

    - provide funding and coordination.

3. The State shall not assume operational control except in cases of rights violations or systemic failure.

Section 8. Funding and Financial Structure

(a) Crisis Care Infrastructure Fund

The State shall establish a dedicated fund to support:

- facility development,
- staffing,
- operational costs.

(b) Funding Model

Funding shall include:

1. Base regional allocations,
2. Episode-based payments,
3. Outcome-based incentives,
4. Penalties for rights violations or systemic failures.

(c) Access Protection

No individual shall be denied necessary crisis care due to inability to pay.

Section 9. Operational Standards

(a) Facility Design

Facilities shall:

- avoid carceral design,
- promote recovery and dignity,
- ensure safe and humane conditions.

(b) Staffing Requirements

Facilities must maintain:

- licensed clinical leadership,
- 24/7 medical coverage where required,
- trained de-escalation personnel.

(c) Discharge Planning

No individual shall be discharged without:

- a documented care plan,
- housing or placement arrangement,

- follow-up care coordination.

Section 10. Data Transparency and Accountability

The State shall require public reporting of:

- hospitalization rates,
- ER boarding times,
- restraint incidents,
- mortality and adverse events,
- readmission rates,
- housing stability outcomes.

All data shall protect individual privacy while ensuring system accountability.

Section 11. Assisted Outpatient Treatment (AOT)

(a) Authorization

Courts may order AOT for individuals with:

- repeated crisis cycling,
- demonstrated inability to adhere to treatment,
- risk of deterioration.

(b) Safeguards

AOT shall include:

- full due process protections,
- guaranteed access to services,
- periodic judicial review.

Section 12. Implementation

(a) Phased Rollout

The State shall implement this Act in phases:

1. Crisis access expansion,
2. Facility development,
3. System optimization.

(b) Rulemaking Constraint

All regulations adopted under this Act must satisfy:

1. Preservation of due process,
2. Adherence to least restrictive care,
3. Maintenance of subsidiarity,
4. Equal protection regardless of socioeconomic status.

Failure to meet these criteria shall render the regulation invalid.

Section 13. Severability

If any provision of this Act is found invalid, remaining provisions shall remain in effect.

Appendix A
Capacity Planning and Cost Estimate Framework

Appendix A.1 Purpose

This Appendix establishes a population-based planning model for estimating facility capacity, staffing needs, and projected costs necessary to implement the Ordered Liberty Mental Health Crisis Care Act.

The purpose of this Appendix is to:

1. Provide a scalable implementation framework
2. Establish moderate baseline capacity targets
3. Allow structured expansion over time
4. Ensure fiscal transparency and planning consistency

This Appendix shall serve as guidance for State and County Crisis Care Boards when implementing the Act.

Appendix A.2 Population-Based Capacity Model

(a) Capacity Planning Standard

Each State shall plan crisis care infrastructure using a population-based model measured per 100,000 residents.

(b) Baseline Capacity Targets

Each region shall establish the following minimum baseline capacity:

Per 100,000 Residents:

1. Crisis Stabilization Unit Beds:

10–12 beds

2. Acute Psychiatric Care Beds:

8–10 beds

3. Subacute Recovery Beds:

6–8 beds

4. Supportive Housing Units:

20–30 units

(c) Expansion Capability

Infrastructure shall be designed to allow expansion to the following recommended long-term targets:

Per 100,000 Residents:

1. Crisis Stabilization Unit Beds:

12–16 beds

2. Acute Psychiatric Care Beds:

10–14 beds

3. Subacute Recovery Beds:

8–12 beds

4. Supportive Housing Units:

30–50 units

Appendix A.3 Facility Distribution Model

(a) Hybrid Facility Model

Implementation shall utilize a hybrid facility structure consisting of:

1. Local Crisis Stabilization Units
2. Regional Acute Psychiatric Facilities
3. Local Subacute Recovery Facilities
4. Distributed Supportive Housing

(b) Local Access Requirement

Each county or regional authority shall ensure:

1. Access to Mobile Crisis Response Services
2. Access to Walk-In Crisis Centers
3. Access to Crisis Stabilization Units within reasonable travel distance

(c) Regional Coordination

Acute Psychiatric Care Facilities may be regionally shared across counties where population density permits.

Appendix A.4 Mobile Crisis Team Capacity

Each region shall maintain:

1. One Mobile Crisis Team per 100,000 residents, minimum
2. Additional teams based on call volume and geographic need

Each Mobile Crisis Team shall include:

1. Licensed clinical professional
2. Trained behavioral health responder
3. Medical support capability as required

Appendix A.5 Staffing Framework

(a) Staffing Ratios

Facilities shall maintain staffing consistent with patient safety and recovery standards.

Recommended baseline staffing ratios:

1. Crisis Stabilization Units

1 clinical staff per 4–6 patients

2. Acute Psychiatric Facilities

1 clinical staff per 3–5 patients

3. Subacute Recovery Facilities

1 clinical staff per 6–8 patients

(b) Additional Staffing

Facilities shall also include:

1. Licensed psychiatrists or psychiatric nurse practitioners
2. Social workers
3. Peer support specialists
4. Security personnel trained in de-escalation
5. Medical staff as appropriate

Appendix A.6 Capital Cost Estimates

Estimated construction costs shall vary by region and facility type.

Estimated baseline construction costs:

1. Crisis Stabilization Units

Estimated Cost Per Bed:

$350,000 – $550,000

2. Acute Psychiatric Facilities

Estimated Cost Per Bed:

$500,000 – $850,000

3. Subacute Recovery Facilities

Estimated Cost Per Bed:

$250,000 – $450,000

4. Supportive Housing Units

Estimated Cost Per Unit:

$180,000 – $350,000

States and counties may utilize:

1. Renovation of existing facilities
2. Adaptive reuse of buildings
3. Modular construction
4. Public-private partnerships

Appendix A.7 Operating Cost Estimates

Estimated annual operating costs:

1. Crisis Stabilization Units

$800,000 – $1.5 million per 10 beds annually

2. Acute Psychiatric Facilities

$2 million – $4 million per 10 beds annually

3. Subacute Recovery Facilities

$1 million – $2 million per 10 beds annually

4. Supportive Housing

$12,000 – $25,000 per resident annually

Appendix A.8 Five-Year Implementation Timeline

Implementation shall occur in phases:

Year 1:

- Mobile Crisis Teams
- Walk-In Crisis Centers
- Initial Crisis Stabilization Units

Year 2:

- Expansion of Crisis Stabilization Units
- Initial Acute Facilities

Year 3:

- Subacute Recovery Facilities

Year 4:

- Supportive Housing Expansion

Year 5:

- System Optimization and Capacity Expansion

Appendix A.9 Long-Term Cost Savings

Implementation of this Act is expected to reduce:

1. Emergency room utilization
2. Jail and incarceration costs
3. Homelessness services expenditures
4. Repeated crisis interventions
5. Law enforcement burden

States shall track cost savings annually and reinvest savings into system expansion.

Appendix A.10 Scalability

This framework shall be scalable for:

1. Small counties
2. Large metropolitan areas
3. Multi-county regions
4. Statewide implementation

States may adjust capacity levels based on:

1. Geographic considerations
2. Population density
3. Existing infrastructure
4. Workforce availability

Appendix A.11 Fiscal Responsibility

Implementation shall prioritize:

1. Cost-effective facility design
2. Use of existing infrastructure
3. Phased expansion
4. Outcome-based investment

States shall avoid unnecessary construction where existing facilities may be repurposed.

Appendix B
Funding and Fiscal Responsibility Framework

Appendix B.1 Purpose

This Appendix establishes funding mechanisms for the Ordered Liberty Mental Health Crisis Care System that prioritize fiscal responsibility, minimize taxpayer burden, and avoid increases to public debt or structural deficits.

This Appendix shall guide States and County Crisis Care Boards in developing sustainable funding strategies.

Appendix B.2 Funding Principles

Implementation of this Act shall adhere to the following principles:

1. No long-term structural deficits
2. No reliance on unsustainable borrowing
3. Preference for reallocation of existing expenditures
4. Incentivization of cost-saving outcomes
5. Protection of patient access regardless of income

Appendix B.3 Reallocation of Existing Expenditures

States and counties shall prioritize reallocation of existing expenditures associated with:

1. Emergency Room psychiatric boarding
2. Law enforcement mental health responses
3. Jail and incarceration of mentally ill individuals
4. Homelessness crisis response services
5. Repeated emergency interventions

Savings from these categories shall be redirected toward crisis care infrastructure and operations.

Appendix B.4 Emergency Room Cost Savings

(a) Background

Emergency departments frequently serve as de facto mental health facilities, resulting in:

1. Extended boarding times
2. High operational costs
3. Reduced emergency capacity

(b) Savings Allocation

States shall track reductions in psychiatric boarding and allocate cost savings toward:

1. Crisis Stabilization Units
2. Mobile Crisis Teams
3. Walk-In Crisis Centers

Appendix B.5 Criminal Justice Cost Savings

(a) Background

A significant portion of incarcerated individuals experience untreated mental illness.

(b) Savings Allocation

Cost savings from reduced incarceration shall be redirected toward:

1. Crisis stabilization services
2. Subacute recovery facilities
3. Supportive housing

Appendix B.6 Homelessness Expenditure Reallocation

(a) Background

Untreated mental illness contributes to chronic homelessness.

(b) Funding Reallocation

States and municipalities shall redirect portions of homelessness expenditures toward:

1. Supportive housing
2. Subacute recovery facilities
3. Community-based stabilization programs

Appendix B.7 Medicaid and Federal Funding Optimization

States shall maximize use of:

1. Medicaid reimbursement
2. Federal mental health grants
3. Crisis response funding programs
4. Behavioral health integration funding

States shall prioritize reimbursement models that reward stabilization and recovery outcomes.

Appendix B.8 Public-Private Partnerships

States and counties may utilize public-private partnerships to:

1. Develop facilities
2. Provide supportive housing
3. Expand community-based services

Such partnerships must:

1. Preserve patient rights
2. Maintain transparency
3. Avoid profit-driven detention incentives

Appendix B.9 Outcome-Based Funding Model

States may implement outcome-based funding structures tied to:

1. Reduced ER utilization
2. Reduced incarceration
3. Reduced homelessness
4. Reduced repeat crisis cycling
5. Improved housing stability

Funding incentives shall reward measurable improvements.

Appendix B.10 Social Impact Funding (Optional)

States may utilize:

1. Social impact bonds
2. Performance-based contracts
3. Pay-for-success models

These mechanisms shall only be used when:

1. Rights protections remain intact
2. Cost savings are measurable
3. Long-term sustainability is demonstrated

Appendix B.11 Phased Funding Structure

Funding shall align with implementation phases:

Year 1:
- Mobile Crisis Teams
- Walk-In Centers

Year 2:

- Crisis Stabilization Units

Year 3:

- Acute Facilities

Year 4:

- Subacute Facilities

Year 5:

- Supportive Housing Expansion

Appendix B.12 Fiscal Safeguards

Funding structures shall prohibit:

1. Incentives for unnecessary institutionalization
2. Payment structures based on confinement duration
3. Profit incentives tied to involuntary detention

Appendix B.13 Transparency Requirements

States shall publish annual reports detailing:

1. Total program costs
2. Cost savings
3. Funding sources
4. Reallocation amounts

All reports shall be publicly accessible.

Appendix B.14 Long-Term Fiscal Impact

Implementation of this Act is expected to:

1. Reduce emergency care costs
2. Reduce incarceration costs
3. Reduce homelessness expenditures
4. Reduce repeated crisis intervention costs

States shall reinvest savings into:

1. Capacity expansion
2. Workforce development

3. Preventive services

Appendix B.15 Estimated National Cost Framework

(a) Population Baseline

United States population: approximately 335 million.

Using the moderate capacity model described in Appendix A:

Per 100,000 residents:

Crisis Stabilization Unit Beds:
10–12 beds

Acute Psychiatric Beds:
8–10 beds

Subacute Recovery Beds:
6–8 beds

Supportive Housing Units:
20–30 units

(b) Estimated National Capacity

Crisis Stabilization Beds:
Approximately 36,000 beds

Acute Psychiatric Beds:
Approximately 30,000 beds

Subacute Recovery Beds:
Approximately 23,000 beds

Supportive Housing Units:
Approximately 85,000 units

(c) Estimated Capital Costs

Crisis Stabilization Beds
Estimated Cost Per Bed: $450,000
Estimated Total: $16.2 billion

Acute Psychiatric Beds
Estimated Cost Per Bed: $650,000

Estimated Total: $19.5 billion

Subacute Recovery Beds

Estimated Cost Per Bed: $350,000

Estimated Total: $8.05 billion

Supportive Housing

Estimated Cost Per Unit: $250,000

Estimated Total: $21.25 billion

(d) Total Capital Cost

Estimated Total National Cost:

Approximately $65 billion

Five-Year Implementation Estimate:

Approximately $13 billion annually

Appendix B.16 Reallocation Opportunities

(a) Emergency Room Psychiatric Boarding

Estimated Annual Cost:

$5–8 billion annually

Estimated Potential Savings (50% reduction):

$2.5–4 billion annually

(b) Jail and Incarceration of Mentally Ill Individuals

Estimated Annual Cost:

$9–12 billion annually

Estimated Potential Savings (25% reduction):

$2–3 billion annually

(c) Homelessness Services

Estimated Annual Spending:

$15–20 billion annually

Estimated Potential Reallocation (20%):

$3–4 billion annually

(d) Law Enforcement Crisis Response

Estimated Annual Cost:

$4–6 billion annually

Estimated Potential Savings (25% reduction):

$1–1.5 billion annually

(e) Total Potential Annual Reallocation

Emergency Room Savings

$2.5–4 billion

Criminal Justice Savings

$2–3 billion

Homelessness Savings

$3–4 billion

Law Enforcement Savings

$1–1.5 billion

Estimated Total Annual Reallocation:

Approximately $8.5–12.5 billion annually

(f) Fiscal Impact

These savings may substantially offset implementation costs and support long-term sustainability without requiring new debt or structural deficits.

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Appendix C

Anonymous Data Collection and System Improvement Framework

Appendix C.1 Purpose and Necessity of Anonymity

(a) Purpose

This Appendix establishes a standardized framework for anonymous data collection to evaluate system performance, identify systemic shortcomings, and guide continuous improvement of mental health crisis care.

(b) Necessity of Anonymity

All data collected under this Act shall be anonymized to protect individual privacy, civil liberties, and dignity.

Anonymous data collection is necessary to:

1. Protect individuals from stigma and discrimination
2. Preserve civil liberties and privacy protections
3. Encourage honest clinical documentation
4. Enable comprehensive data collection without fear of misuse
5. Maintain public trust in the system

(c) Prohibition of Identifying Information

Data collected under this Appendix shall not include:

1. Names
2. Social Security numbers
3. Addresses
4. Dates of birth
5. Photographs
6. Biometric identifiers
7. Any combination of data capable of identifying an individual

(d) Data Security

States shall implement safeguards to ensure:

1. Data encryption
2. Limited access
3. Secure storage

4. Auditable access controls

Appendix C.2 Required Data Categories

States and facilities shall collect anonymized data including, but not limited to:

(a) Demographic Data

1. Age or age range
2. Biological sex
3. Identified gender
4. General geographic region (non-identifying)
5. Race or ethnicity (optional and self-reported)
6. Religious affiliation, spiritual identification, or irreligious/atheist identification (optional and self-reported)

(b) Clinical Data

1. Primary diagnosis
2. Secondary diagnoses
3. Symptom categories
4. Severity indicators
5. Co-occurring conditions

(c) Substance Use Data

1. Alcohol use
2. Prescription drug misuse
3. Illicit drug use
4. Polysubstance use

(d) Behavioral Indicators

1. Self-harm risk
2. Harm to others risk
3. Psychosis indicators
4. Cognitive impairment
5. Functional impairment

(e) Criminal Justice Interaction

1. Prior arrest history (non-identifying)
2. Prior incarceration history (non-identifying)
3. Court involvement

4. Diversion program participation

(f) Social Stability Indicators

1. Housing stability
2. Employment status
3. Family or community support
4. Access to healthcare

(g) Demographic Safeguards

1. Demographic data shall be voluntary
2. Individuals may decline to answer
3. Demographic data shall not determine treatment eligibility
4. Demographic data shall be used only for aggregate analysis
5. Demographic data shall not be used for discriminatory purposes

Appendix C.3 System Comparison Framework

(a) Purpose

States shall compare outcomes between:

1. Existing mental health response systems
2. Ordered Liberty Crisis Care Systems

(b) Comparison Metrics

Comparisons shall include:

1. Emergency room utilization
2. Crisis response times
3. Hospitalization rates
4. Involuntary commitment rates
5. Repeat crisis events
6. Arrest rates
7. Incarceration rates
8. Homelessness rates
9. Mortality rates
10. Adverse event rates

(c) Baseline Data

States shall establish baseline measurements prior to implementation.

(d) Longitudinal Tracking

States shall track outcomes:

1. Yearly
2. Five-year intervals
3. Ten-year intervals

Appendix C.4 Data-Driven System Improvements

(a) Continuous Improvement Requirement

States shall utilize anonymized data to:

1. Identify system weaknesses
2. Improve facility distribution
3. Improve staffing levels
4. Improve treatment approaches
5. Improve crisis response

(b) Early Warning Indicators

States shall identify trends including:

1. Rising crisis rates
2. Increased involuntary commitments
3. Increased adverse events
4. Workforce shortages

(c) Policy Adjustments

States shall adjust:

1. Funding allocation
2. Facility capacity
3. Training requirements
4. Operational protocols

(d) Public Reporting

States shall publish anonymized reports including:

1. System performance

2. Outcome improvements

3. Identified challenges

4. Recommended improvements

Appendix C.5 Civil Liberties Safeguards

(a) Prohibited Uses

Data collected under this Appendix shall not be used for:

1. Law enforcement targeting

2. Population control policies

3. Eugenic practices

4. Surveillance of individuals

(b) Oversight

Civil Liberties Ombuds Office shall monitor:

1. Data collection

2. Data use

3. Compliance with privacy protections

Appendix C.6 Research and Innovation

States may utilize anonymized data to:

1. Improve treatment methods

2. Improve crisis intervention strategies

3. Improve recovery outcomes

4. Develop preventative care models

All research must preserve anonymity and civil liberties.

Appendix D
Abuse Prevention, Accountability, and Penalties

Appendix D.1 Purpose

This Appendix establishes strict safeguards, accountability measures, and penalties to prevent abuse of authority within the Ordered Liberty Mental Health Crisis Care System.

The purpose of this Appendix is to:

1. Protect individual rights and liberties
2. Prevent coercive or unjust institutionalization
3. Prevent political misuse of mental health systems
4. Maintain public trust
5. Establish meaningful consequences for abuse

Appendix D.2 Definition of Abuse of Power

Abuse of power under this Act shall include, but is not limited to:

(a) Improper Admission

1. Admitting an individual without meeting legal criteria
2. Admitting an individual for political or personal reasons
3. Admitting an individual as retaliation

(b) Improper Detention

1. Detaining an individual without proper review
2. Extending detention without legal justification
3. Preventing lawful discharge

(c) Denial of Rights

1. Denial of legal representation
2. Denial of communication with family or advocate
3. Denial of review hearings

(d) Fabrication or Manipulation of Records

1. Falsifying clinical documentation
2. Altering records to justify detention
3. Suppressing information favorable to release

(e) Political or Government Misuse

1. Targeting individuals for political beliefs
2. Targeting individuals for religious beliefs
3. Targeting individuals for lawful speech
4. Targeting whistleblowers

(f) Financial Abuse

1. Detention for financial gain
2. Billing fraud
3. Incentivizing unnecessary institutionalization

Appendix D.3 Criminal Penalties

(a) Felony Offense

Abuse of power under this Act shall constitute a felony offense.

(b) Penalties

Individuals found guilty shall be subject to:

1. Imprisonment of not less than 1 year and not more than 20 years
2. Fines not less than $50,000 and not more than $1,000,000
3. Permanent prohibition from public office
4. Permanent prohibition from healthcare leadership roles

(c) Enhanced Penalties

Enhanced penalties shall apply when:

1. Abuse involves multiple individuals
2. Abuse involves minors
3. Abuse involves extended detention
4. Abuse results in physical or psychological harm

Enhanced penalties may include:

1. Imprisonment up to 25 years
2. Fines up to $2,000,000

Appendix D.4 Civil Penalties

(a) Right to Civil Action

Individuals subjected to abuse under this Act shall have the right to civil action.

(b) Civil Damages

Courts may award:

1. Compensatory damages
2. Emotional damages
3. Punitive damages

(c) Mandatory Minimum Civil Penalties

Courts shall impose minimum civil penalties:

1. $25,000 for improper admission
2. $50,000 for improper detention
3. $100,000 for fabricated records
4. $250,000 for political targeting

(d) Tax-Free Compensation

All damages awarded under this Appendix shall be:

1. Paid directly to affected individuals
2. Exempt from federal taxation
3. Exempt from state taxation

Appendix D.5 Personal Liability

(a) No Immunity

Officials, administrators, and clinicians shall not be protected by qualified immunity for abuse of power under this Act.

(b) Personal Responsibility

Individuals responsible for abuse shall be personally liable.

(c) Insurance Restrictions

Professional liability insurance shall not cover intentional abuse of authority.

Appendix D.6 Whistleblower Protections

(a) Protection

Individuals reporting abuse shall be protected from:

1. Termination
2. Retaliation
3. Harassment

(b) Whistleblower Rewards

Whistleblowers may receive:

1. Up to 30% of imposed fines
2. Legal protection

Appendix D.7 Oversight and Investigation

(a) Independent Review Board

Each state shall establish an independent oversight board.

(b) Authority

The board shall have authority to:

1. Investigate complaints
2. Review detention decisions
3. Refer cases for prosecution

(c) Public Reporting

States shall publish anonymized reports of:

1. Complaints
2. Investigations
3. Outcomes

Appendix D.8 Immediate Release Provision

If abuse is identified:

1. Immediate review shall occur
2. Release shall occur if detention is unjustified
3. Legal counsel shall be provided immediately

Appendix D.9 Statute of Limitations

Claims under this Appendix may be filed:

1. Within 10 years of the incident
2. Or within 5 years of discovery of abuse

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Appendix E
Patient Rights and Due Process Protections

Appendix E.1 Purpose

This Appendix establishes patient rights and due process protections within the Ordered Liberty Mental Health Crisis Care System.

The purpose of this Appendix is to:

1. Protect individual liberty
2. Protect human dignity
3. Ensure due process
4. Prevent unlawful detention
5. Maintain public trust

Appendix E.2 Fundamental Rights

All individuals admitted under this Act shall retain the following rights:

1. Right to dignity and humane treatment
2. Right to privacy
3. Right to communication
4. Right to religious or philosophical expression
5. Right to legal representation
6. Right to review and appeal

These rights shall not be denied except when necessary to prevent immediate harm.

Appendix E.3 Admission Standards

(a) Voluntary Admission

Individuals may voluntarily seek admission.

Voluntary patients shall retain the right to request discharge.

Facilities shall process discharge requests promptly unless:

1. The individual presents immediate danger to self or others
2. Legal review determines continued care is necessary

(b) Emergency Admission

Emergency admission may occur when:

1. The individual poses immediate danger to self
2. The individual poses immediate danger to others
3. The individual is unable to care for basic needs due to severe impairment

Emergency admission shall require:

1. Clinical evaluation
2. Documentation of justification
3. Independent review within 72 hours

Appendix E.4 Due Process Protections

(a) Notice of Rights

Individuals shall receive written notice of:

1. Reason for admission
2. Rights retained
3. Appeal process

(b) Legal Representation

Individuals shall have the right to:

1. Legal counsel
2. Court-appointed counsel if necessary

(c) Hearing Requirement

Individuals shall receive:

1. Review hearing within 7 days
2. Periodic review thereafter

Appendix E.5 Duration Limits

(a) Initial Emergency Hold

Emergency holds shall not exceed:

72 hours without independent review

(b) Extended Care

Extended care shall require:

1. Judicial authorization
2. Periodic review

(c) Periodic Review

Review shall occur:

1. Every 14 days for short-term care
2. Every 30 days for long-term care

Appendix E.6 Communication Rights

Individuals shall have the right to:

1. Contact family
2. Contact legal counsel
3. Contact patient advocates

Communication may only be restricted to prevent immediate harm.

Appendix E.7 Religious and Philosophical Rights

Individuals shall retain the right to:

1. Religious practice
2. Spiritual care
3. Philosophical expression

Facilities shall make reasonable accommodations.

Appendix E.8 Humane Treatment Standards

Facilities shall ensure:

1. Safe environment
2. Clean living conditions
3. Adequate nutrition
4. Medical care
5. Therapeutic programming

Appendix E.9 Least Restrictive Care Requirement

Facilities shall provide care in the least restrictive setting appropriate.

Preference shall be given to:

1. Local facilities

2. Voluntary care
3. Community-based programs

Appendix E.10 Family and Advocate Involvement

Individuals may designate:

1. Family members
2. Advocates
3. Legal representatives

These individuals may participate in:

1. Care planning
2. Review hearings

Appendix E.11 Discharge Rights

Individuals shall have:

1. Right to discharge planning
2. Right to follow-up care
3. Right to community reintegration

Appendix E.12 Civil Liberties Protection

Nothing in this Act shall:

1. Authorize indefinite detention
2. Authorize political detention
3. Authorize coercive treatment without review

Appendix F
Facility Design and Care Model

Appendix F.1 Purpose

This Appendix establishes facility design standards and care models for the Ordered Liberty Mental Health Crisis Care System.

The purpose of this Appendix is to:

1. Promote humane care
2. Support recovery and stability
3. Preserve dignity and liberty
4. Provide appropriate levels of care
5. Encourage reintegration into community life

Appendix F.2 Tiered Facility Structure

(a) County-Level Facilities

Each county shall establish smaller local facilities designed for:

1. Short-term stabilization
2. Voluntary care
3. Early intervention
4. Crisis prevention

County-level facilities shall prioritize:

1. Accessibility
2. Family involvement
3. Community integration

(b) Regional Facilities

States shall establish regional facilities designed for:

1. Moderate to severe cases
2. Longer stabilization periods
3. Structured treatment programs

Regional facilities shall serve multiple counties.

(c) State-Level Intensive Facilities

States shall establish one to two intensive care facilities designed for:

1. Severe psychiatric crises
2. Complex or resistant conditions
3. High-risk individuals requiring intensive care

These facilities shall provide:

1. Advanced treatment capabilities
2. Specialized staff
3. Intensive therapeutic programming

Appendix F.3 Humane Environment Standards

Facilities shall be designed to:

1. Avoid prison-like environments
2. Promote calm and stability
3. Encourage dignity and respect

Facilities shall include:

1. Natural lighting
2. Outdoor access
3. Green space
4. Quiet areas
5. Comfortable living spaces

Appendix F.4 Nature-Based Design

Facilities shall incorporate nature-based elements including:

1. Gardens
2. Walking paths
3. Outdoor seating
4. Natural landscapes

Nature-based design shall aim to:

1. Reduce stress
2. Promote healing
3. Improve mental stability

Appendix F.5 Faith and Philosophical Accommodation

Facilities shall:

1. Permit religious practice
2. Permit spiritual care
3. Permit philosophical expression

Facilities shall provide:

1. Quiet reflection spaces
2. Access to spiritual advisors upon request

Participation shall be voluntary.

Appendix F.6 Therapeutic Care Model

Facilities shall provide traditional and integrative therapies.

(a) Traditional Therapies

Traditional therapies may include:

1. Psychiatric care
2. Medication management
3. Individual therapy
4. Group therapy
5. Cognitive behavioral therapy

(b) Integrative Therapies

Integrative therapies may include:

1. Art therapy
2. Music therapy
3. Occupational therapy
4. Movement therapy
5. Nature-based therapy

Appendix F.7 Tactile and Kinetic Therapy Support

Facilities shall provide options for tactile and kinetic individuals including:

1. Gardening programs
2. Workshop or hands-on activities

3. Exercise programs
4. Outdoor activities

These programs shall aim to:

1. Improve stability
2. Improve engagement
3. Promote recovery

Appendix F.8 Least Restrictive Care Principle

Facilities shall prioritize:

1. Voluntary care
2. Short-term stabilization
3. Community reintegration

Movement between facility tiers shall occur only when necessary.

Appendix F.9 Family and Community Integration

Facilities shall encourage:

1. Family involvement
2. Community support
3. Reintegration planning

Appendix F.10 Facility Size Guidelines

Facilities shall aim for:

1. Smaller county facilities
2. Moderate regional facilities
3. Limited state-level intensive facilities

This structure shall prevent:

1. Over-centralization
2. Institutional abuse
3. Large-scale detention environments

Appendix F.11 Recovery-Oriented Design

Facilities shall promote:

1. Personal responsibility

2. Skill development
3. Stability

Programs may include:

1. Life skills training
2. Social skills development
3. Financial literacy

Appendix G
Staffing and Training Standards

Appendix G.1 Purpose

This Appendix establishes staffing, training, and operational standards for the Ordered Liberty Mental Health Crisis Care System.

The purpose of this Appendix is to:

1. Ensure high-quality care
2. Protect patient dignity
3. Prevent abuse
4. Prevent staff burnout
5. Maintain safe and stable facilities

Appendix G.2 Professional Standards

All staff shall maintain standards exceeding typical professional requirements.

Staff shall demonstrate:

1. Professional competence
2. Respectful conduct
3. Discipline
4. Humility
5. Commitment to patient dignity

Facilities shall prioritize hiring individuals demonstrating:

1. Emotional stability
2. Patience
3. Compassion
4. Professional maturity

Appendix G.3 Clinician-to-Patient Ratios

Facilities shall maintain clinician-to-patient ratios designed to exceed minimum industry standards.

Ratios shall:

1. Allow individualized care
2. Allow emergency surge capacity

3. Prevent staff overload

States shall establish ratio standards that prioritize:

1. Safety
2. Stability
3. Recovery

Appendix G.4 Support Staff Requirements

Each clinician shall be supported by adequate staff including:

1. Nursing staff
2. Behavioral health technicians
3. Administrative staff
4. Communication staff

Support staff levels shall exceed minimum operational requirements.

Appendix G.5 Cross Training

Facilities shall provide cross training for:

1. Nursing staff
2. Behavioral support staff
3. Reception staff
4. Communication staff

Cross training shall allow:

1. Gap coverage
2. Emergency flexibility
3. Operational continuity

Appendix G.6 Rotating Schedules

Facilities shall implement rotating schedules to:

1. Prevent burnout
2. Maintain staff wellness
3. Maintain alertness

Rotations shall include:

1. Adequate time off

2. Predictable scheduling
3. Coverage redundancy

Appendix G.7 Spiritual Advisors and Faith Leaders

Facilities shall provide access to spiritual advisors.

(a) Availability

Spiritual advisors shall be available:

1. 24 hours per day
2. On-call and in-person

(b) Diversity

Facilities shall provide multiple advisors including:

1. Multiple religious traditions
2. Non-religious philosophical support

(c) Coverage

Facilities shall ensure:

1. Overlapping coverage
2. Break periods
3. Rotational scheduling

Participation shall be voluntary.

Appendix G.8 Security Staff Standards

Security staff shall:

1. Maintain calm demeanor
2. Prioritize de-escalation
3. Avoid law-enforcement style approaches

Security staff shall be trained in:

1. De-escalation techniques
2. Safe restraint methods
3. Crisis response

Appendix G.9 Medical Emergency Training

Security staff shall be trained to:

1. Recognize psychiatric emergencies
2. Recognize medical emergencies
3. Assist clinical staff

Security staff may assist in:

1. Emergency restraint
2. Emergency medication administration under supervision

Appendix G.10 Staff Wellness

Facilities shall prioritize staff wellness including:

1. Adequate breaks
2. Time off
3. Counseling availability

Staff wellness programs shall aim to:

1. Reduce burnout
2. Improve performance
3. Improve retention

Appendix G.11 Continuing Education

Staff shall receive continuing education including:

1. De-escalation training
2. Patient rights training
3. Clinical updates
4. Cultural competence training

Appendix G.12 Accountability

Facilities shall implement:

1. Performance reviews
2. Complaint review systems
3. Quality improvement programs

Appendix H
Community Reintegration Framework

Appendix H.1 Purpose

This Appendix establishes a structured community reintegration framework for individuals transitioning from Ordered Liberty Mental Health Crisis Care facilities.

The purpose of this Appendix is to:

1. Support long-term recovery
2. Prevent relapse
3. Reduce repeat crises
4. Promote independence
5. Encourage stable reintegration into society

Appendix H.2 Gradual Reintegration

Individuals transitioning from facilities shall undergo a gradual reintegration process.

This process shall:

1. Be structured
2. Be supervised
3. Be individualized

Reintegration shall occur at a pace appropriate to the individual.

Appendix H.3 Reintegration Phases

Reintegration shall occur in phases including:

(a) Phase One — Structured Transition

Phase One shall include:

1. Frequent check-ins
2. Structured schedules
3. Ongoing clinical oversight

Check-ins may include:

1. In-person visits
2. Telehealth visits

3. Community visits

(b) Phase Two — Reduced Clinical Structure

Phase Two shall include:

1. Moderately spaced check-ins
2. Increased independence
3. Continued support availability

(c) Phase Three — Maintenance Care

Phase Three shall include:

1. Routine therapy schedule
2. Optional support services
3. Crisis prevention planning

(d) Phase Four — Independent Stability

Individuals may transition to:

1. Self-management
2. Optional therapy
3. Periodic wellness check-ins

Participation in this phase shall be voluntary.

Appendix H.4 Individualized Reintegration Plans

Each individual shall receive:

1. Personalized reintegration plan
2. Defined support structure
3. Crisis prevention plan

Plans shall consider:

1. Individual needs
2. Risk factors
3. Support systems

Appendix H.5 Check-In Schedule

Check-ins shall:

1. Begin frequently

2. Gradually decrease over time
3. Transition to maintenance care

Schedules may include:

1. Weekly check-ins
2. Biweekly check-ins
3. Monthly check-ins
4. Maintenance-level care

Appendix H.6 Community Support Integration

Reintegration shall include:

1. Family involvement
2. Community support
3. Voluntary peer support

Participation shall be voluntary.

Appendix H.7 Housing Stability

States shall encourage support for:

1. Stable housing
2. Transitional housing
3. Independent living

Appendix H.8 Employment and Purpose

Reintegration plans may include:

1. Employment support
2. Educational opportunities
3. Volunteer opportunities

These programs shall promote:

1. Stability
2. Purpose
3. Independence

Appendix H.9 Continued Access to Care

Individuals shall retain access to:

1. Therapy
2. Medication management
3. Crisis support

Access shall remain available even after full reintegration.

Appendix H.10 Early Warning Intervention

Reintegration programs shall include:

1. Early warning identification
2. Rapid response support
3. Preventative intervention

Appendix H.11 Voluntary Participation

Reintegration shall prioritize:

1. Voluntary participation
2. Respect for independence
3. Personal responsibility

Appendix H.12 Long-Term Stability

Programs shall aim to:

1. Reduce repeat crises
2. Promote independence
3. Maintain long-term stability

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